STATE OF MAINE BOARD OF OSTEOPATHIC LICENSURE

142 STATE HOUSE STATION
AUGUSTA, ME 04333-0142
Phone: (207) 287-2480
www.maine.gov/osteо

Please Note:
To apply for a Doctor of Osteopathic license, please print pages 1 – 13. To apply for a Physician Assistant license, please print pages 14 – 26.
Applying for a Permanent License to Practice Osteopathic Medicine in Maine

The Maine Board of Osteopathic Licensure is responsible for ensuring the health and safety of the public of this State. Through the licensing process, the Board provides assurance that each physician has received his/her degree from an accredited college of osteopathic medicine, has received the appropriate level of training and that no cause exists that would be a basis for disciplinary action of a licensed physician.

Your application must be submitted no less than 90 days prior to the Board meeting at which you would like it to be considered. The Board meets on the second Thursday of each month. See the left sidebar at http://www.maine.gov/osteo/administrative/ for a list of meeting dates.

Your licensure application packet must include the following:

- Completed Uniform Application and addendum.
- Check or money order only (made payable to Maine Board of Osteopathic Licensure) in the amount of $350 (non-refundable). Do not send cash. Credit cards are not currently accepted.
- Any other necessary documentation.

Incomplete applications or those without the fee or required documents will not be processed. Applications will not be reviewed by the Board until such time as a minimum of 2 references (obtained independently, by the Board) have been received.

Please do not contact the Board office for an application update for at least 30 days. After the 30 days, update requests should be submitted via e-mail to osteo.pfr@maine.gov

The Federation Credentials Verification Service (FCVS)

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories. Two of the services provided are the Uniform Application for Physician State Licensure (UA) and the Federation Credentials Verification Service (FCVS).

FCVS staff verifies primary source documents related to your identity, education, training, and more, creating a personalized profile that eliminates the re-verification of items that never change. Your profile can be updated and sent to additional boards as needed.

We recommend that you use FCVS for credentials verification but it is not required for licensure. If you do not use FCVS, you must provide your credentials directly to the board for verification. If you use FCVS, you will still need to complete the UA, but you will not need to complete several of the UA verification forms.

To work on the initial FCVS application for creating a profile or the subsequent FCVS application for updating an existing profile, visit http://www.fsmb.org/ and select FCVS in the Licensure or Sign In menu, then sign in as directed. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.
The Uniform Application for Physician State Licensure (UA)

We are pleased to offer the UA as an option for physicians seeking licensure. After completing the UA for the first time, your application is securely stored and can be sent to another participating board as long as the forms and state-specific requirements are also completed for each board. Updates to the UA can be made as needed.

To work on the UA, go to http://www.fsmb.org/ and select Uniform Application from the Licensure menu or Sign In menu. If you have submitted a UA, select the state board in the State Board section to open the UA for editing. Submit your UA to the board when you have finished updating your UA.

Completing the Uniform Application

Please read the following information carefully before completing and submitting your application. You will be asked to account for all time since medical school graduation, including providing your employment history, and asked to provide any information on medical malpractice claims. We recommend having this information on hand before you begin working on your UA.

First time UA users are required to pay a one-time service charge of $50. Your receipt will be available immediately after submitting your UA, and you will receive a separate receipt via email.

The UA FAQ at https://www.fsmb.org/uniform-application/ua-faq/ answers the most common UA questions. If your question or issue isn’t listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org. Provide your username and FCVS ID number if applicable. If you receive an error, email a screenshot of the error along with a description of what you were doing at the time to ua@fsmb.org.

Please note the following:

- Provide both your current home address and current practice/training address, otherwise an error will occur. Do not enter the same address for both home and work.
- MD and DO licenses cannot be added or edited in the UA as all MD and DO license information comes directly into the system from the state boards. Email ua@fsmb.org with the correct information if changes are needed.
- Enter all other professional licenses (nurse, EMT, physician assistant, etc.) you have held (active or inactive) in the U.S. or Canada. Request verification from these boards as well.
- If you hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper to the Board.
- If you have no malpractice claims, you may leave that section blank. If you do have a claim, indicate in the “specifics” section whether the claim/suit involved the death of a patient, wrong sided surgery or loss of limb/major organ. Also provide a copy of the documents related to the suit/claim.
  
  If the status of a suit is 1) pending – submit a copy of court’s Complaint and a letter from your attorney indicating the status of the case 2) dismissed – submit a copy of the court’s Dismissal Order or 3) settled – submit a copy of court’s Complaint, Final Disposition, and Settlement/Release.
- To open an already submitted UA for editing, select the Board from the State Board section. Update your UA as needed, then submit your UA to the Board.
In addition to completing the core UA online, all applicants must:

- Submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent to the Board, not to FCVS or FSMB. Attach a recent (fewer than 90 days old) two inch by two inch (2” x 2”) passport quality, color photograph of yourself in the space provided.

- Have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the U.S. or Canada verified by the granting board, whether the license or certification is active or inactive. Determine the fees and verification method for each board using the licensure verification resource at https://www.fsmb.org/uniform-application/ua-faq/.

Use the UA Licensure Verification Form for boards that need a written request. If the verifying board uses VeriDoc or another method, use VeriDoc or the preferred method instead of using the UA form.

If you are using FCVS for credentials verification,

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

If you are not using FCVS for credentials verification,

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if your name is not the same on all of your submitted documents.

- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at https://www.fsmb.org/uniform-application/ua-faq/.

- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form. The UA Medical School Verification form should be accompanied by a copy of your diploma if you graduated from that school. A certified transcript must be sent to the Board from the appropriate educational institution. If your transcript or any other document submitted is in a language other than English, also provide a certified translation.

- If you are an International Medical Graduate, request from ECFMG that your ECFMG certificate, Fifth Pathway Program Certificate, and/or FMGEMS certificate be sent to the Board, as applicable. See the UA FAQ at the link above for contact information.

Other Licensure Requirements

National Practitioner Data Bank Self Query
- Visit https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp and begin the process for the Self-Query. Follow all instructions given. After your Self-Query has been processed, they will send the report directly to you. Open this report to make sure that the results were not rejected and all information is correct. Forward all parts of this report directly to our office for final review. For questions or assistance, call 800-767-6732 or email help@npdb.hrsa.gov.
Physician Profile Data Report from AOA
- Request the AOA Official Osteopathic Physician Profile Report at [https://www.doprofiles.org](https://www.doprofiles.org). For questions or assistance, email credentials@osteopathic.org.

**Uniform Application for Physician State Licensure Checklist**

After completing the online application, you are responsible for submitting certain documents. Please use the checklist that applies to you (not using or using FCVS to verify credentials).

<table>
<thead>
<tr>
<th>Item</th>
<th>Not Using FCVS</th>
<th>Using FCVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed online Uniform Application and state addendum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sent addendum, application fee, and any other required documentation to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed licensure verification with each state board with which you have ever held any healthcare license.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLEX exam takers only: Contacted the Maine Board of Osteopathic Licensure about the exam in Osteopathic Practices &amp; Principles.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sent National Practitioner Data Bank report to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sent Physician Profile Data Report from the American Osteopathic Association (AOA) to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sent notarized copy of birth certificate or current, valid passport to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Sent supporting documentation of any legal name change to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Sent Medical School Verification form (Form #2) and a copy of your diploma to each medical school attended.</td>
<td></td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Sent Postgraduate Training Verification form (Form #3) to all training programs attended.</td>
<td></td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Sent a copy of your postgraduate training certificate(s) to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td>Completed via FCVS</td>
</tr>
<tr>
<td>Sent all examination transcripts to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td>Completed via FCVS</td>
</tr>
</tbody>
</table>
Uniform Application Addendum

Name: ____________________________ Proposed Practice Site: ____________________________

Please answer all questions. If any of the following questions are answered “yes”, full details must be furnished on a separate sheet and attached to the application. (To the extent allowed by law, all answers will be kept confidential.)

In the past five (5) years, have you:

Yes ☐ No ☐

1. Had a disabling physical or mental illness(es) that resulted in any hospitalization or that prevented you from working or carrying out your usual daily responsibilities for more than thirty (30) days?

☐ ☐ 2. Been told by a professional or peer that you have an ongoing medical (including substance abuse) surgical or psychiatric condition that has or could impair your practice of medicine, or been advised to seek treatment for any of these conditions?

☐ ☐ 3. Been addicted to or abused any of the substance or drug (including the use of alcohol)?

Now or at any time in the past, have you:

Yes ☐ No ☐

4. Been arrested or convicted for anything other than minor traffic violations (DUI is not considered a minor traffic violation)?

☐ ☐ 5. Had findings of sexual misconduct made against you (including sexual harassment)?

☐ ☐ 6. Been notified of an investigation or complaint or had any disciplinary action or sanction (including find) taken against you (voluntary or otherwise) by the licensing board of this state or any other jurisdiction?

☐ ☐ 7. Had your staff privileges at any hospital, nursing home, or other health provider terminated, reduced, revoked, restricted, suspended, or been put on probation by any of these facilities or providers, voluntary or otherwise?

☐ ☐ 8. Been notified of an investigation or complaint or been sanctioned in any way by a professional society?

☐ ☐ 9. Been notified of an investigation or complaint or had any sanction, recoupment, or other adverse action of any kind taken against you by a third party reimbursement program, whether private or government financed (such as Medicare or Medicaid)?
10. In anticipation of or during the pendency of any investigation or other disciplinary proceeding (whether by a state board, hospital, health care provider, or peer review) voluntarily surrendered any professional license, certificate, registration, or privileges issued to you?

☐ ☐

11. Had any malpractice award(s), judgment(s), or settlement(s) against you? (If yes, also fill out the malpractice page in the UA.)

☐ ☐

12. Been involved in any medical malpractice claim or lawsuit, or been notified by an insurance company that a claim may be filed against you? (If yes, also fill out the malpractice page in the UA.)

☐ ☐

13. Lost your medical malpractice insurance coverage or had an application denied for any reason?

☐ ☐

14. Been notified of an investigation or complaint or had any adverse action or sanction (e.g., suspension, restrictions, revocation) taken against you whether voluntary or otherwise by the DEA? (If yes, also list, if any, your current DEA license number and the state where the license was issued: ____________________________, State: ______________________

☐ ☐

15. Discontinued practice for any reasons for a period of one month or more?

☐ ☐

16. Applied for licensure or to sit for an examination, or taken an examination, under a different name?

☐ ☐

Please provide specific details to any affirmative answers.

All questions must be answered and the fee must be included or the application will not be processed!

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional business associates (past and present), medical malpractice carrier and all government agencies and instrumentalities (state and federal) to release to this licensing board any information, files, or records required by the board for its evaluation of any professional and ethical qualifications or licensure in the State of Maine.

Dated: ______________________  Signature of Applicant: ____________________________

Type or Print Name: ____________________________
Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at [http://www.fsmb.org/policy/contacts](http://www.fsmb.org/policy/contacts).

Please send this form to:
State of Maine Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

**Applicant Photograph**
Securely tape or glue a recent (per the board’s instructions) front-view 2” x 2” passport-type color photo of yourself in this square.

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Applicant's signature (must be signed in the presence of a notary)

Applicant’s printed last name, first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left]

**NOTARY**

State of ________________________, County of ________________________.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant’s signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of __________, 20____.

Notary Public Signature ________________________________ My Notary Commission Expires ________________

Uniform Application for Licensure October 2018
Licensure Verification Form (Form #1)

Applicant: Most boards require verification of each professional license ever held. Refer to the licensure verification resource at [http://www.fsmb.org/licensure/uniform-application/](http://www.fsmb.org/licensure/uniform-application/) to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at [http://www.fsmb.org/policy/contacts](http://www.fsmb.org/policy/contacts) to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

Verifying Board: Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

Section 1: Applicant Information

First name ___________________________ Last name ___________________________ Practitioner Type □ MD □ DO □ __
Middle name ___________________________ Suffix ________ SSN* ____________ Birth date (mm/dd/yyyy) ____________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of ____________ to provide any and all information pertaining to my license number ____________ to the board at the address listed below.

Board name State of Maine Board of Osteopathic Licensure
Mailing address 142 State House Station
City/State/Zip Augusta, ME 04333-0142

Applicant signature ___________________________ Date ____________

Section 2: Board Verification of Licensure

Name of issuing board or license entity ___________________________
Name of licensee (last, first, middle, suffix) ___________________________
License type ____________ License number ____________ Issue date ____________ Expiration date ____________

1. Is this license current? If not current, please explain: □ Yes □ No

2. Have formal disciplinary proceedings been initiated against this applicant’s license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form.

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant’s license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ___________________________ Print name ___________________________

AFFIX INSTITUTIONAL SEAL HERE

Title ___________________________ Date ____________

(If no seal is available, this form must be notarized.) Phone number ___________________________ Fax number ___________________________
Email ___________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.
Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician’s transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name __________________ Last name __________________ Practitioner Type ☐ MD ☐ DO ☐ ___
Middle name __________________ Suffix ______ SSN* ____________ Birth date (mm/dd/yyyy) ____________
Name if different when diploma awarded: ______________________________________________________
Name of school ________________________________________________________________

*The social security number is to be used for purposes of identification only and may not be used in any other reason.

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name State of Maine Board of Osteopathic Licensure
Mailing address 142 State House Station
City/State/Zip Augusta, ME 04333-0142

Applicant signature ___________________________________________ Date ________________

Section 2: Medical or Osteopathic School Verification

School name ________________________________________________________________
Complete address w/country _________________________________________________
School name if different when applicant attended ______________________________
Hours of undergraduate education required for admission ______ Total weeks of education applicant attended ______
Attendance (mm/yyyy) from ______ to _______ Graduation date __________ Degree awarded __________

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual’s medical or osteopathic education. Check the appropriate responses and provide dates and requested information. “Yes” responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her Yes ☐ No ☐ medical/osteopathic education? If Yes, indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved.

☐ Personal or family From ___________ to ___________ Approved ☐ Unapproved ☐
☐ Academic remediation From ___________ to ___________ Approved ☐ Unapproved ☐
☐ Health From ___________ to ___________ Approved ☐ Unapproved ☐
☐ Financial From ___________ to ___________ Approved ☐ Unapproved ☐
☐ Participation in a joint degree program From ___________ to ___________ Approved ☐ Unapproved ☐
☐ Participation in a non-research special study (e.g., fellowship, intl. experience) From ___________ to ___________ Approved ☐ Unapproved ☐
☐ Other ___________________________ From ___________ to ___________ Approved ☐ Unapproved ☐
2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? Yes □ No □ If yes, indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome.

- □ Academic  From _________________ to _________________  Documentation attached
- □ Unprofessional conduct  From _________________ to _________________  Documentation attached
- □ Behavioral reasons  From _________________ to _________________  Documentation attached
- □ Other _________________  From __________ to __________  Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? Yes □ No □ If yes, explain below and/or attach documentation or information of each circumstance and outcome.

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? Yes □ No □ If yes, explain below and/or attach documentation or information of each circumstance and outcome.

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes □ No □ If yes, explain below and/or attach documentation or information of each circumstance and outcome.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ________________________________
Print name ______________________________

AFFIX INSTITUTIONAL SEAL HERE
Title ______________________________ Date ____________
(If no seal is available, this form must be notarized.) Phone number ______________ Fax number ___________
Email ________________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.
**Postgraduate Training Verification Form (Form #3)**

**Institution Name:**

**Institution Address:**

**Affiliated School:**

**Applicant:** Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

**Program Director or designated Official:** Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

**Board Information:**

To be completed by the applicant.

**Waiver for Release of Information:** I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any information pertaining to my training there to the board listed below:

**Board Name:** State of Maine Board of Osteopathic Licensure

**Mailing address:** 142 State House Station, Augusta, ME 04333-2480

**Applicant Signature**

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**Section 1:** To be completed by the Applicant.

**Name:**

**Suffix**

**Practitioner type:** M.D. [ ] D.O. [ ]

**Date of birth:** (mm/dd/yyyy)

**SSN**

*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**Name if different when diploma awarded:**

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**Section 2:** Program Participation:

**Important:**

**Report Incomplete Training Levels (years) separate from those that were successfully completed.**

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

**Report Internships, Residencies, and Fellowships separately.**

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**Unusual Circumstances:**

Check the appropriate responses and explain any "Yes" or omitted responses. Attach a separate sheet of paper if needed.

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**Certification:**

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

**I CERTIFY THAT** to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). (Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)

**Signature:**

**Print name:**

**Title:**

**Email address:**

**Phone Number:**

**Date:**

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Uniform Application for Physician Licensure

October 2018
Fifth Pathway Verification Form (Form #4)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

Program Director or Designated Official: Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

Section 1: Applicant Information

First name ___________________ Last name ___________________ Practitioner Type ☐ MD ☐ DO ☐ ___
Middle name ___________________ Suffix _______ SSN* _______________ Birth date (mm/dd/yyyy) _______________

Name if different when diploma was awarded: __________________________________________________________________________
Name of medical school _________________________________________________________________________________________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

Board name ___________________ State of Maine Board of Osteopathic Licensure
Mailing address ___________________ 142 State House Station
City/State/Zip ___________________ Augusta, ME 04333-0142

Applicant signature ___________________ Date ________________

Section 2: Fifth Pathway Verification

Institution name ___________________ Affiliated school ___________________
Institution name if different when applicant attended __________________________________________________________________________
Institution address w/country ______________________________________________________________________________________________

Type of Clinical Rotation From To Weeks Credit
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Completed? ☐ Yes. Attendance was from __________ to __________. Completion date was ________________.
☐ No. Withdrawal* date was ________________ . *If the applicant withdrew or was dismissed, please explain below.
☐ No. Dismissal* date was ________________ . *If the applicant withdrew or was dismissed, please explain below

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ____________________________
Print name ______________________________

AFFIX INSTITUTIONAL SEAL HERE
Title ______________________________ Date ________________

(If no seal is available, this form must be notarized.) Phone number ______________ Fax number ______________
Email ________________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

Uniform Application for State Licensure

October 2018
STATE OF MAINE BOARD OF OSTEOPATHIC LICENSURE

142 STATE HOUSE STATION
AUGUSTA, ME 04333-0142
Phone: (207) 287-2480
www.mainet.gov/osteo

Please Note:

To apply for a Doctor of Osteopathic license, please print pages 1 – 13. To apply for a Physician Assistant license, please print pages 14 – 26.
TO BE CONSIDERED FOR LICENSURE IN THE STATE OF MAINE, AN APPLICANT MUST SATISFY THE FOLLOWING REQUIREMENTS:

1. Submit an administratively complete application.
2. Pay the appropriate fee ($200);
3. Have successfully completed an educational program for physician assistants accredited by the American Medical Association Committee on Allied Health Education and Accreditation, or the Commission for Accreditation of the Allied Health Education Programs, or their successors;
4. Have no license, certification or registration as a physician assistant, or any other type or classification of health care provider license, certification or registration under current discipline, revocation, suspension, restriction or probation;
5. Have no cause existing that may be considered grounds for disciplinary action or denial of licensure as provided by law;
6. Pass, at the time of license application, a jurisprudence examination administered by the Board; and
7. Have passed the NCCPA certification examination and holds a current certification issued by the NCCPA that has not been subject to disciplinary action by the NCCPA at the time the license application is acted upon by the Board.
INSTRUCTIONS FOR PERMANENT LICENSE APPLICATION

HOW TO APPLY

Before you complete this application, please review the Requirements for Licensure. APPLICATION FEES ARE NOT REFUNDABLE. Incomplete applications or those received without the required fee or documents will not be processed. Applications will not be reviewed until all appropriate materials are received. Please type or print clearly in ink.

The following statement is made pursuant to the Privacy Act of 1974, Section 7(b):

Disclosure of your social security number is mandatory for tax administration purposes pursuant to 36 M.R.S. § 175 as authorized by 42 U.S.C. § 405 (c)(2)(c)(i).
Disclosure of your social security number is mandatory for purposes of enforcement of child support orders pursuant to 10 M.R.S. § 8003(4-A) and as authorized by 42 U.S.C. § 405 (c)(2)(c)(ii).
Disclosure of your social security number will occur in accordance with National Practitioner Data Bank reporting requirements pursuant to 45 C.F.R. §§ 60.8, 60.9.
Any other disclosure of your social security number shall be as permitted by applicable law.

Procedures:
1. Board Application:

   (a) Complete Sections 1 through 8 of the State of Maine Uniform Application for Physician Assistant Licensure. You must respond to all components of the application as instructed.

   (b) The Board requires BOTH your HOME mailing address and phone number, and the address and phone number of the PRINCIPAL LOCATION WHERE YOU WILL BE RENDERING MEDICAL SERVICES. You may designate which of the two addresses you wish to be used to receive mailings from the Board (by checking the “contact at” box). If you fail to designate a contact address for mailings, all correspondence from the Board will be sent to your home address. Unless you specify otherwise, your business address will be the address circulated by the Board in listings and publications available to the general public, including the Internet. If you currently have no business address and you do not wish for your home address to be on the Internet, you must provide an alternate address, such as a Post Office box, or a mail drop. If, subsequent to this application, your home or business contact information changes, you must immediately notify the Board. Immediately upon beginning to render medical services in Maine, you must provide the Board with your primary business address and phone number.

   (c) Complete Section 8, Affidavit of Applicant, in the presence of a Notary Public. The Notarial seal must cover a portion of the photograph, and the photo must fit within the box.

   (d) Provide complete addresses in Section 6. Failure to do so will delay licensure.
2. Necessary Additional Documents

(a) Copy of Diploma with original Notary signature

(b) Original Transcript

(c) Up to date curriculum vitae (education and work history)

(d) Self-query NPDB Report - Visit [https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp](https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp) and begin the process for the self-query. Follow all instructions provided. After your self-query has been processed, a report will be e-mailed directly to you, followed by an original via US Mail. Please check the report to be sure the results were not rejected and that all information is correct. If the information is correct, you may forward the e-mail containing the pdf document to Osteo.PFR@maine.gov. You may forward the original sent via US Mail to the Board or retain it. Should you have any questions or need assistance, please call the NPDB directly at 800/767-6732 or via e-mail at help@npdb.hrsa.gov.

(e) $200 Application Fee

3. Malpractice Claims:

Your insurance carrier or attorney must provide an independent detailed explanation of all malpractice claims. This information must be received directly from the insurance company or attorney. This information is in addition to your personal explanation.

Application form items 19 & 20, regarding professional (malpractice) liability claims experience, are the questions most likely to generate follow-up letters from the Board staff and delay your licensure if not answered completely. Report all claims of which you have been noticed, as well as all claims from which you were dismissed as a defendant or for which your insurance company made a settlement of any kind with the plaintiff, or any claim for which a court found you liable in any degree. A reporting form is provided. Claims against a professional corporation are considered a claim against the individual licensee who provided the professional services in dispute. To be complete, your supplemental explanation must include, for each such claim reported, a full description using the Professional (Malpractice) Liability Claims Experience Form. See the following fictitious example:

Identity of Case: Burns v. John B. Doe, MD, Samuel E. Smith, MD, Topeka Woman’s Hospital, Inc. et al.; Kansas Third Circuit Court, Topeka, Case #89-10203

Date/Place of Original Occurrence: June 4, 1990, Topeka Woman’s Hospital

Malpractice Alleged by Claimant: Delayed diagnosis of ectopic pregnancy.

Summary of my Defense: I was a PGY II resident at the time. Dr. Samuel E. Smith, Chief of Obstetrics, Topeka Woman’s Hospital was attending physician in this case. I was named in the claim because my name appears in the chart as the physician ordering ultrasonography on first hospital day.

Current Status of Case: Although a motion to dismiss me as a defendant is pending, my insurance company has offered a settlement on my behalf of $15,000.00 on February 14, 1992. I have been told the plaintiff rejected this and the claim is still pending.
4. Submitting the Board Application:

   (a) Your application will be submitted electronically to the board and you will receive an e-mail from noreply@maine.gov with instructions to complete the jurisprudence exam and the application addendum.

**OTHER IMPORTANT INFORMATION**

1. We find that it takes on average 90 days to receive responses to all of the inquiries requested in order to have a completed application packet.

2. State Examination covering Maine law and Board rules and regulations (Jurisprudence Exam).

   All applicants are required to complete a written examination, which is an open book exam. Instructions will be provided once your application is received.

3. Renewal date (License and Registration*).

   The renewal date of your license and registration is determined by your date of birth. As a result, your first license and registration will typically not be for a full period of 2 years (depending on the timing of your application).

4. Time Expectations.

   The process of verifying your credentials and qualifications takes an average of 90 days. Your Board application, scored written exam, and supporting documentation will be presented for review when deemed administratively complete. The Board usually meets every month to consider license applications.

* A Registration of a supervising physician is NOT required for licensure only. However, a registration is required prior to rendering of any medical services in the State of Maine.
PLEASE NOTE

Mandated Reporter Requirements for Suspected Child Abuse

Maine law requires that physicians immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the physician assistant knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. In addition, if a child is under 6 months of age or otherwise non-ambulatory, Maine law requires physicians assistants to immediately report to DHHS if that child exhibits evidence of the following: fracture of a bone; substantial bruising or multiple bruises; subdural hematoma; burns; poisoning; or injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ, except that the reporting of injuries occurring as a result of the delivery of a child attended by a licensed medical practitioner or the reporting of burns or other injuries occurring as a result of medical treatment following the delivery of the child when the child remains hospitalized following the delivery is not required. Please refer to 22 M.R.S. § 4011-A for all reporting requirements.

Mandated Reporter Training and additional information regarding mandated reporting can be found at: http://www.maine.gov/dhhs/ocfs/cps/

Maine Prescription Monitoring Program (PMP)

As of August 1, 2014, Maine law requires all Allopathic Physicians, Osteopathic Physicians, Dentists, Physician Assistants, Podiatrists, and Advanced Practice Registered Nurses who are licensed to prescribe scheduled medications to register with the Prescription Monitoring Program (PMP). To register, please go to the Prescription Monitoring Program website: http://www.maine.gov/pmp  Download, complete and sign a registration form located within the yellow box. You may mail, scan and email or fax a signed form to the information located on the form. Please note there are two types of registration forms available, 1) Data Requester form for active prescribers with a DEA number and, 2) Sub-Account form for assistants/non-prescribing health professionals.

As of January 1, 2017, upon initial prescription of a benzodiazepine or an opioid medication to a person and every 90 days for as long as that prescription is renewed, a prescriber shall check prescription monitoring information for records related to that person.

More PMP information is available at: http://www.maine.gov/dhhs/samhs/osa/data/pmp/prescriber.htm

Prescribers should make regular use of the PMP

Maximum Opioid Medication Limits

As of July 29, 2016, an individual may not prescribe to a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day unless the patient meets certain exceptions. For more information, visit the Boards’ websites.
# Uniform Application Physician Assistant Checklist for Licensure

Send this checklist with all other materials being sent to the Board that you are applying to.

**NOTE:** If required items are not submitted, then the application will be considered incomplete and will not be processed until all items requested are received.

<table>
<thead>
<tr>
<th>Item</th>
<th>NOT using FCVS to verify credentials</th>
<th>Using FCVS to verify credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed and submitted online Uniform Application to the Board.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Notarized UA Affidavit and Authorization for Release of Information</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>form with 2x2 photo taken within the past 3 months sent to the Board.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCCPA Certification sent to the Board.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Current National Practitioner Data Bank Self-Query sent to the Board.</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sent notarized copy of birth certificate or current, valid passport</td>
<td>□</td>
<td>FCVS handles</td>
</tr>
<tr>
<td>to the Maine Board of Osteopathic Licensure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting documentation of any legal name change sent to the Board.</td>
<td>□</td>
<td>FCVS handles</td>
</tr>
<tr>
<td>Physician Assistant Program official transcripts sent directly to</td>
<td>□</td>
<td>FCVS handles</td>
</tr>
<tr>
<td>the Board by your Physician Assistant program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A notarized copy of your Physician Assistant Program diploma.</td>
<td>□</td>
<td>FCVS handles</td>
</tr>
</tbody>
</table>
Maine Board of Osteopathic Licensure

Addenda Instructions for Physician Assistant

Complete each addendum as instructed. Please type or print your responses. Return the completed addenda along with any and all supporting documentation to the Maine Board of Osteopathic Licensure.

☐ Addendum 1  **Professional References.** Please furnish the names and address of three persons under whose supervision you have worked as a PA during the most recent periods of employment (or preceptors, if you are applying as a new graduate from a PA program). These references will be contacted for a professional assessment.

☐ Addendum 2  **Personal Data.** Check off (X) each appropriate response. Every ‘YES’ response must be fully explained by a written statement on a separate 8.5” X 11” sheet of white paper. Each such explanation must be cross-referenced with a question number number, and must be signed, dated, and enclosed with your application.

Please return completed addenda and payment to the:

Maine Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142
www.maine.gov/osteo
Addendum 1: Professional References

Please furnish the names and addresses of three persons under whose supervision you have worked as a Physician Assistant during the most recent periods of employment (or preceptors, if you are applying as a new graduate from a PA program). These references will be contacted for a professional assessment.

Name: _____________________________________________ Title: _____________________________
Address:_____________________________________________________________________________________

Email: _____________________________________________ Fax: _________________________________

Name: _____________________________________________ Title: _____________________________
Address:_____________________________________________________________________________________

Email: _____________________________________________ Fax: _________________________________

Name: _____________________________________________ Title: _____________________________
Address:_____________________________________________________________________________________

Email: _____________________________________________ Fax: _________________________________

Addendum 2: Personal Data

Check off (X) each appropriate response. Every ‘YES’ response must be fully explained by a written statement on a separate 8.5” x 11” sheet of white paper. Each such explanation must be cross-referenced with the question number, and must be signed, dated, and enclosed with your application.

YES NO

☐ ☐ 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?

☐ ☐ 2. Have you EVER agreed with any licensing authority to voluntarily follow practice limitations, restrictions, guidelines, to make reports or to complete specific continuing education or course work?

☐ ☐ 3. Have you EVER been notified of the existence of allegations, investigations and/or complaints involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations, investigations and/or complaints remain open as of the date of this application?
4. Have you EVER left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint, investigation or allegation was pending?

5. Have you EVER been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to:
   a) The U. S. Drug Enforcement Administration (US DEA)?

   YES NO

   b) Any state/territory of the U. S., INCLUDING MAINE?

6. Has there EVER been a finding by any state or federal court or governmental agency that you violated any rule or law regulating the practice of health care?

7. Has there EVER been a finding against you in any inquiry, investigation, or administrative or judicial proceeding by an employer, educational institution, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure?

8. Have you EVER received a sanction or entered into any settlement agreement or integrity agreement related to Medicare, TRICARE or any state Medicaid program?

9. The purpose of the following questions is to determine the current fitness of the applicant to render medical services. The following inquiries concern medical, mental health, and substance misuse issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or substance misuse is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by substance misuse or a medical or mental health condition.

   a. Do you have a mental or physical condition that currently impairs your ability to safely and competently render medical services?

   b. Within the last five (5) years have you been diagnosed with or treated for any medical or mental health disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?

   c. Do you currently use any chemical substance(s), including alcohol, which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?

If any of your answers to questions 9(a-c) is “Yes,” are the limitations or impairments caused by your medical, mental health, or substance misuse condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program? Current voluntary participation in the Medical Professionals Health Program or similar program will be kept confidential.
d. Are you currently engaged in the illegal use of illicit drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate healthcare provider-patient relationship? “Legitimate” means “Being in compliance with the law or in accordance with established and accepted standards.”

☐ ☐

e. Have you EVER used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate healthcare provider-patient relationship?

YES NO

☐ ☐

f. Have you ever obtained illegal drugs or prescription drugs that were not prescribed to you pursuant to a legitimate healthcare provider-patient relationship?

☐ ☐

g. Have you EVER furnished or provided illegal drugs to anyone other than medical marijuana per applicable state law?

☐ ☐

h. Have you EVER furnished prescription drugs to or written a prescription for anyone without having a legitimate physician assistant-patient relationship (This includes conduct for which you may NOT have been adjudicated in any civil, administrative or criminal proceeding)?

i. Have you EVER been found in any civil, administrative or criminal proceeding to have:

☐ ☐

Possessed, used, prescribed for use, or distributed any drugs in any way other than for legitimate or therapeutic purposes?

☐ ☐

Diverted any drugs?

☐ ☐

Violated any drug law?

☐ ☐

Prescribed any controlled substances for yourself or family/household members?

☐ ☐

j. Within the last five (5) years have you EVER raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or substance misuse disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?

☐ ☐

10. Have you EVER been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses such as Operating Under the Influence, but not minor traffic or parking violations.

☐ ☐

11. Have you EVER applied for hospital, HMO or other health care entity privileges which were denied?

☐ ☐

12. Have you EVER had your staff privileges or employment at any hospital, long term care facility, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?
13. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?

14. Have you EVER resigned from employment in lieu of termination or while under investigation?

YES NO

15. Have you EVER been terminated or suspended from any employment?

16. Have you EVER been deselected from a managed care organization panel?

17. Have you EVER been disciplined by a professional society or resigned while an accusation was pending?

18. Have you EVER endangered the safety of others, breached fiduciary obligations, or violated workplace conduct rules?

19. Have you EVER been named in any medical malpractice liability claim or lawsuit adjudicated by a court in favor of the other party, or settled by you or your insurance company/representatives with or without your express consent?

20. Do you have any open/pending malpractice claims?

21. Do you intend to render medical services within the State of Maine without active medical staff privileges at a Maine hospital?

22. Do you plan to practice telemedicine in Maine? If so, please provide a short description of your plan to practice with Maine Patients, including your practice protocols, your physical practice location, your publicly available telemedicine website portal, and whether you will be combining in-person medical practice with telemedicine.
Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. Send this form to the board you are applying to for licensure. Include all other required materials.

Please send this form to: State of Maine Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public. Send this notarized affidavit to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB. Doing so will delay your state licensure.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician Assistant State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license.

Applicant Photograph

Securely tape or glue a recent (less than 3 month old) front-view 2” x 2” passport-type color photo of yourself in this square.

Notary seal must overlap a portion of this photograph but not covering the neck or head.

Applicant’s signature (must be signed in the presence of a notary)

Applicant’s printed last name

Applicant’s printed first name, middle initial, and suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

Notary

State of ____________________________, County of ____________________________.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photographer's identification document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of ______________________, 20____.

Notary Public Signature: ____________________________________________

My Notary Commission Expires: ________________________________

(NOTARY PUBLIC SEAL)